

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

601 NEW JERSEY AVENUE, NW

SUITE 9500

WASHINGTON, DC 20001

August 29, 2006

SECRETARY OF LABOR,	:	Docket Nos. PENN 2004-73-R
MINE SAFETY AND HEALTH	:	PENN 2004-74-R
ADMINISTRATION (MSHA)	:	PENN 2004-75-R
	:	PENN 2004-85-R
v.	:	PENN 2004-86-R
	:	PENN 2004-87-R
CUMBERLAND COAL RESOURCES, LP	:	PENN 2004-88-R
	:	PENN 2004-104-R
	:	PENN 2004-105-R
	:	PENN 2004-181
	:	PENN 2005-8

BEFORE: Duffy, Chairman; Jordan, Suboleski, and Young, Commissioners

DECISION

BY THE COMMISSION:

In these contest and civil penalty proceedings arising under the Federal Mine Safety and Health Act of 1977, 30 U.S.C. § 801 et seq. (2000) (“Mine Act”), Administrative Law Judge Michael E. Zielinski affirmed two imminent danger orders and three citations issued by the Department of Labor’s Mine Safety and Health Administration (“MSHA”) to Cumberland Coal Resources, LP (“Cumberland”) alleging that Cumberland had violated 30 C.F.R. § 75.334(b)(1).¹ 27 FMSHRC 295 (Mar. 2005) (ALJ). Cumberland filed a petition for discretionary review of the

¹ Section 75.334(b)(1) sets forth requirements for the function of a bleeder system in an underground coal mine as follows:

During pillar recovery a bleeder system shall be used to control the air passing through the area and to continuously dilute and move methane-air mixtures and other gases, dusts, and fumes from the worked-out area away from active workings and into a return air course or to the surface of the mine.

30 C.F.R. § 75.334(b)(1).

judge's decision, which the Commission granted. For the reasons that follow, we affirm the judge's decision in part and reverse in part.

I.

Factual and Procedural Background

Cumberland operates the Cumberland Mine, a large, underground coal mine in Greene County, Pennsylvania. *Id.* at 296. In 2003, Cumberland was preparing to mine Longwall Panel No. 49 ("LW49") which, at a size of more than 12,000 feet long and 1,250 feet wide, was to be the largest panel that Cumberland had ever mined. *Id.* at 296-97. For ventilation purposes, Cumberland initially had planned to use a bleeder fan system, in which bleeder entries would be connected to a bleeder shaft located inby, or behind, LW49. *Id.* at 297. However, Cumberland realized that LW49 would be ready for production weeks or even months before the bleeder shaft would be operational. *Id.* In October 2003, Cumberland abandoned plans to use the bleeder shaft and, instead, decided to use a wraparound bleeder system for the first 10,000 feet of mining on LW49. *Id.* With the wraparound bleeder system, airflow would be generated by existing fans located outby LW49 used to pull air out of the tailgate entries. *Id.*; Jt. Stip. 14. On November 7, Cumberland submitted to MSHA an addendum to its ventilation plan,² describing provisions specific to LW49, and proposing that, in April 2004, a bleeder shaft would be constructed within an air shaft located outby LW49 to enhance the ventilation system. 27 FMSHRC at 297. On December 9, MSHA approved the ventilation plan addendum for the first 8,000 feet of mining. *Id.*; Jt. Exs. 1 & 1A.

On December 28, mining activity began on LW49. 27 FMSHRC at 298. In early January 2004, LW49 experienced a number of "gas outs," i.e., interruptions in mining due to high levels of methane measured by monitors located at the longwall face and tailgate.³ *Id.* Cumberland then made three changes in the airflow of the LW49 ventilation system without seeking or obtaining MSHA's prior approval. *Id.* at 298-99. First, on January 4, Cumberland changed the No. 3 tailgate entry from an intake to a return air course. *Id.* at 298; Jt. Stip. 19. Second, on January 7, Cumberland reversed the direction of airflow in the No. 1 headgate entry (the belt entry) to move air outby from the face, and switched the No. 3 headgate entry from a return to an intake air course. 27 FMSHRC at 299; Jt. Stip. 20. Cumberland sent a letter to MSHA requesting approval of these changes on January 8. 27 FMSHRC at 299; Jt. Ex. 3. Third, on January 11, Cumberland moved a regulator located on the tailgate side to change pressure from outby to inby. 27 FMSHRC at 299; Jt. Stip. 22. Cumberland submitted an addendum to its ventilation plan, incorporating these changes, on January 12. 27 FMSHRC at 299; Jt. Ex. 4.

² Cumberland's ventilation plan had been approved on March 3, 2003. 27 FMSHRC at 298; Jt. Stip. 16; Jt. Ex. 2.

³ The mine is very gassy and is subject to spot inspections every 5 days pursuant to section 103(i) of the Mine Act, 30 U.S.C. § 813(i). 27 FMSHRC at 298.

On January 13, MSHA Inspector Anthony Guley and MSHA Assistant District Manager Thomas Light conducted a spot inspection of the mine pursuant to section 103(i) of the Mine Act, 30 U.S.C. § 813(i). 27 FMSHRC at 299. Guley and Light were concerned by conditions they encountered on LW49, including low airflows and higher than expected methane concentrations, which they believed indicated that the bleeder system was not working adequately. *Id.* at 300-01. Guley and Light observed the changes that had been made and determined that the December 9 ventilation plan was no longer being followed. *Id.* at 299. Guley thereupon issued Cumberland a citation pursuant to section 104(a) of the Mine Act, 30 U.S.C. § 814(a), for failure to obtain MSHA’s approval before implementing changes to its ventilation plan.⁴ *Id.*

On January 14, representatives of MSHA, Cumberland, and the United Mine Workers of America (“UMWA”) participated in a meeting at which the LW49 ventilation system was discussed. *Id.* at 301. MSHA scheduled a comprehensive ventilation survey of LW49 to be conducted on January 16. *Id.* On January 15, Cumberland performed its own evaluation of the bleeder system and determined that it was working effectively. *Id.*

On January 16, MSHA, Cumberland, and UMWA representatives conducted a ventilation survey of the LW49 wraparound bleeder system. *Id.* at 301-02; Tr. 471-72. Approximately seven teams, consisting of three or four people each, collected information about the bleeder system by taking altimeter readings to determine ventilating pressures, anemometer readings to determine airflow velocities, pressure gauge readings to determine pressure differentials, smoke tube readings to determine airflow directions and airflow velocities for specific distances, and methane readings using handheld detectors and bottle samples. 27 FMSHRC at 301; Jt. Stip. 27; Jt. Ex. 7; Tr. 87-88, 466-67, 471-81, 487. Based on the results of the survey, MSHA determined that the bleeder system was fragile and was ineffectively ventilating the longwall panel. 27 FMSHRC at 302; Tr. 162-63, 503-05; Gov’t Exs. 25 & 26. Consequently, MSHA Inspector Robert Penigar issued Cumberland Citation No. 7083200 alleging a violation of section

⁴ The citation, which is not at issue in these proceedings, alleged a violation of 30 C.F.R. § 75.370(a)(1) and (d), which require that an “operator shall develop and follow a ventilation plan approved by the district manager” and that material changes to the plan must be approved before implementation. 27 FMSHRC at 299-300; Jt. Ex. 5.

75.334(b)(1).⁵ 27 FMSHRC at 302. Cumberland agreed not to operate LW49 until the ventilation problems were resolved. *Id.*

On January 18, MSHA, Cumberland, and UMWA personnel met to discuss changes to the LW49 wraparound bleeder system. *Id.* On January 19, MSHA re-evaluated the bleeder system but, despite improvements, MSHA determined that the system remained ineffective. *Id.*; Tr. 548-49; Gov't Exs. 27 & 28. Additional changes were made, and another evaluation was performed on January 20. 27 FMSHRC at 302; Gov't Exs. 29 & 30. Although the bleeder system was improved, MSHA determined that it was still fragile and its capacity to dilute methane was limited. 27 FMSHRC at 302.

On the night of January 20, the survey results and MSHA's requirements for approval of a new ventilation plan were discussed at a meeting. *Id.* MSHA insisted upon additional monitoring points because it believed that, due to lack of airflow in the No. 2 tailgate entry, the designated bleeder evaluation points ("BEPs") were not providing accurate information about conditions in the bleeder system. *Id.*; Tr. 167. Specifically, in addition to BEPs 30, 30A, and 30B,⁶ MSHA required monitoring points within the gob at crosscuts 82 and 85, using steel pipes installed through stoppings between the No. 1 and No. 2 tailgate entries so that methane in the

⁵ Citation No. 7083200 states:

The bleeder system for the active LW49 longwall section, MMU 011, was determined to be ineffective in controlling the flow of air through the bleeder system to continuously dilute and move methane-air mixtures from the gob and away from the active workings. A ventilation survey conducted by MSHA inspectors and engineers from MSHA Technical Support on 01/16/2004 showed that the bleeder system was not adequate to move methane out of the gob and away from the face. The operator was cited on 01/13/2004 for not complying with the ventilation plan approved on December 9, 2003 when it was found the longwall was not being ventilated in a manner approved in the plan. Coal will not be mined with the longwall until ventilation changes are made to correct the bleeder system deficiencies and a plan submitted and approved by the District Manager showing the revised bleeder system.

Gov't Ex. 1 at 1. The citation designates the violation as significant and substantial ("S&S") and characterizes the operator's degree of negligence as moderate. *Id.*

⁶ BEPs 30 and 30B were located inby the longwall face at the back corner on the tailgate side of LW49. BEP 30A was moveable in advance of the longwall face on the tailgate side of LW49. Jt. Exs. 1A & 10A; Tr. 286, 394, 1314-15.

No. 2 tailgate entry⁷ could be measured by testing air flowing through the pipes into the No. 1 tailgate entry. 27 FMSHRC 302. MSHA also required a monitoring point in the No. 1 tailgate entry between crosscuts 73 and 74. *Id.* MSHA insisted upon specific methane limits at those monitoring points, i.e., limits of 4.5% for the BEPs and the monitoring points at crosscuts 82 and 85 and 2.0% for the monitoring point between crosscuts 73 and 74. *Id.*

Cumberland objected to MSHA's gob-sampling requirements as unprecedented and unreasonable. *Id.* Nevertheless, on January 21, Cumberland submitted and MSHA approved a new ventilation plan incorporating MSHA's requirements. *Id.* at 303; Jt. Exs. 10 & 10A. As the operation of LW49 resumed, MSHA inspectors were assigned to monitor the bleeder system 24 hours a day, taking measurements at the established monitoring points every 2 hours. 27 FMSHRC at 304, 316. On January 24, MSHA Inspector Ronald Hixson issued an imminent danger order pursuant to section 107(a) of the Mine Act, 30 U.S.C. § 817(a), and a citation alleging a violation of section 75.334(b)(1) when he measured methane concentrations above 5.0% at a location in the No. 2 tailgate entry of LW49 between crosscuts 83 and 84. *Id.* at 304; Gov't Exs. 2, 3, & 33. On January 25, MSHA re-evaluated the bleeder system and determined that it was still fragile. 27 FMSHRC at 304; Tr. 588, 603; Gov't Ex. 32.

On January 29, representatives from Cumberland met with Assistant Secretary of Labor for Mine Safety and Health David Lauriski and other MSHA personnel to complain that MSHA's insistence upon the additional monitoring points and methane limits within the gob was unprecedented and unjustified. 27 FMSHRC at 305; Jt. Stip. 42. The meeting, however, did not resolve Cumberland's complaint. 27 FMSHRC at 305. Cumberland then sought assurances from MSHA that, if it were to convert the wraparound bleeder system to a bleeder fan system, the monitoring in the No. 2 tailgate entry would no longer be required. *Id.* Cumberland began developing a plan to make operational the previously-planned bleeder shaft behind LW49. *Id.*

On February 4, MSHA Inspector Ronald Tolliver detected sudden increases in methane concentrations along the tailgate side of LW49, including a methane concentration of 4.8% at the monitoring point in the No. 2 tailgate entry in the gob at crosscut 85, and, consequently, issued Cumberland Order No. 7066999 alleging an imminent danger and Citation No. 7067000 for a violation of section 75.334(b)(1).⁸ *Id.* at 304; Gov't Ex. 34. On February 7, Tolliver again

⁷ The No. 2 tailgate entry served as an intake airway outby BEP 30A, but became part of the gob on the inby side of the longwall face. *See* Jt. Ex. 10A.

⁸ Order No. 7066999 states:

The bleeder system used in the no. 49 Longwall panel failed to continuously dilute and move methane air mixtures and dust from the worked out area away from the active section. Methane was detected on the tailgate side, in the no. 2 entry, at the no. 85 crosscut at 4.8%. This was due to an airchange (removal of

detected sudden increases in methane concentrations along the tailgate side of LW49, including a methane concentration of 5.0% at the monitoring point in the No. 2 tailgate entry in the gob at crosscut 85, and issued Order No. 7067001 alleging another imminent danger and Citation No. 7067003 for another violation of section 75.334(b)(1).⁹ 27 FMSHRC at 304; Gov't Ex. 35. Also on that date, MSHA approved Cumberland's plan to make operational the previously-planned bleeder shaft. 27 FMSHRC at 305; Jt. Stip. 48.

a ventilation control in the headgate side of the #2 entry).

Gov't Ex. 5 at 1.

Citation No. 7067000 states:

The bleeder system for the active LW49 longwall section, MMU 011, was determined to be ineffective in controlling the flow of air through the bleeder system to continuously dilute and move methane-air mixtures from the gob and away from the active workings. This was due to an adjustments [sic] to the ventilation controls in the no. 2 entry of the headgate side.

Gov't Ex. 4 at 1. The citation designates the violation as S&S and characterizes the operator's negligence as moderate. *Id.*

⁹ Order No. 7067001 states:

The bleeder system used in the no. 49 Longwall panel failed to continuously dilute and move methane air mixtures and dust from the worked out area away from the active section. Methane was detected on the tailgate side, in the no. 2 entry at the no. 85 crosscut at 5.0%.

Gov't Ex. 6 at 1.

Citation No. 7067003 states, in pertinent part:

The bleeder system for the active LW49 longwall section, MMU 011, was determined to be ineffective in controlling the flow of air through the bleeder system to continuously dilute and move methane-air mixtures from the gob and away from the active workings.

Gov't Ex. 7 at 1. The citation designates the violation as S&S and characterizes the operator's negligence as moderate. *Id.*

Mining activity on LW49 was stopped from February 13 until the bleeder shaft was completed, more than a month later. 27 FMSHRC at 305. On February 14, while miners were moving a regulator on the headgate side of LW49, MSHA Inspector James Conrad issued an imminent danger order and a citation alleging a violation of section 75.334(b)(1) when he detected 5.1% methane at BEP 31 located in the No. 2 headgate entry between crosscuts 88 and 89. *Id.* at 304; Tr. 987-1013; Gov't Exs. 8, 9, & 36. After Cumberland converted to the bleeder fan system, no further ventilation problems or delays were experienced. 27 FMSHRC at 305. Cumberland challenged the orders and citations, and the matter proceeded to hearing.

The judge affirmed the citation issued on January 16 and the orders and citations issued on February 4 and 7, but vacated the orders and citations issued on January 24 and February 14. *Id.* at 332. With regard to the January 16 citation, the judge determined that the bleeder system was not functioning effectively as required by section 75.334(b)(1), and that a reasonably prudent person familiar with the mining industry and the protective purpose of the standard would have recognized the system's ineffectiveness. *Id.* at 305-15. Regarding the February 4 and 7 orders and citations, the judge determined that the sudden increases in methane concentrations presented imminent dangers to miners and that the bleeder system was not functioning effectively, in violation of section 75.334(b)(1). *Id.* at 323-27. The judge concluded that the violations were S&S and the result of moderate negligence. *Id.* at 315-16, 327. Accordingly, he assessed civil penalties totaling \$2,496, the amount proposed by the Secretary for the violations. *Id.* at 332.

II.

Disposition

On appeal, Cumberland argues that substantial evidence does not support the judge's affirmance of the citation issued on January 16 and the orders and citations issued on February 4 and 7.¹⁰ PDR 15-23; C. Br. 17-23, 28-31; C. Reply Br. 2-10. It asserts that the LW49 wraparound bleeder system was functioning adequately and effectively as required by section 75.334(b)(1). *Id.* Cumberland also asserts that the judge erred in determining that it had notice that the bleeder system violated the standard. PDR 11-15; C. Br. 10-17; C. Reply Br. 11-13. In addition, Cumberland argues that the judge erred in finding that the inspector did not abuse his discretion in issuing the imminent danger orders. PDR 23-27; C. Br. 23-27. Cumberland requests that the Commission vacate the orders and citations, as well as the associated civil penalties assessed by the judge.

¹⁰ When reviewing an administrative law judge's factual determinations, the Commission is bound by the terms of the Mine Act to apply the substantial evidence test. 30 U.S.C. § 823(d)(2)(A)(ii)(I). "Substantial evidence" means "such relevant evidence as a reasonable mind might accept as adequate to support [the judge's] conclusion." *Rochester & Pittsburgh Coal Co.*, 11 FMSHRC 2159, 2163 (Nov. 1989) ("*R&P*") (quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938)).

The Secretary responds that the judge's decision should be affirmed. She contends that substantial evidence supports the judge's conclusions that Cumberland violated section 75.334(b)(1) because the citations were based on significant problems with the bleeder system. S. Br. 12-25. The Secretary also asserts that the judge correctly determined that Cumberland was on notice that the bleeder system violated the standard. *Id.* at 25-30. In addition, she argues that the judge correctly found that the inspector did not abuse his discretion in issuing the imminent danger orders. *Id.* at 30-34.

A. Citation No. 7083200 (January 16, 2004)

Section 75.334(b)(1) requires that, during pillar recovery, a bleeder system shall be used "to control the air passing through the area and to continuously dilute and move methane-air mixtures . . . from the worked-out area away from active workings and into a return air course or to the surface of the mine." 30 C.F.R. § 75.334(b)(1). Section 75.334 is derived from section 303(z)(2) of the Mine Act, 30 U.S.C. § 863(z)(2), the purpose of which is to "require bleeder systems continuously to dilute, render harmless, and carry away methane effectively within the bleeder system and to protect active workings from the hazards of methane accumulations." *RAG Cumberland Res. LP*, 26 FMSHRC 639, 647 (Aug. 2004), *aff'd sub nom. Cumberland Coal Res., LP v. FMSHRC*, No. 04-1427, 2005 WL 3804997 (D.C. Cir. Nov. 10, 2005).

The Commission has recognized that, although section 75.334(b)(1) does not literally set forth a requirement that a bleeder system shall function effectively, such a requirement is implicit in the standard's language and is consistent with the standard's underlying statutory purpose. *Id.* Thus, the Commission has read section 75.334(b)(1) to require a bleeder system "to control air passing through the area and continuously to dilute and move methane-air mixtures away from active workings and into a return or to the surface in an effective manner." *Id.* In other words, "a bleeder system must effectively ventilate the area within the bleeder system and protect active workings from the hazards of methane accumulations." *Id.*

Substantial evidence supports the judge's determination that, on January 16, the LW49 wraparound bleeder system was not functioning as required by section 75.334(b)(1). MSHA's survey results show that a very small pressure differential in the No. 2 tailgate entry between crosscuts 83 and 87, i.e., 0.02 inches of water,¹¹ produced airflow in an outby direction. 27 FMSHRC at 310; Gov't Ex. 26 (showing pressures of -0.67 inches of water at crosscut 87 and -0.69 inches of water at crosscut 83, and an airflow quantity of 8,123 cubic feet per minute ("cfm") near crosscut 83); Tr. 519-21. In the No. 2 tailgate entry between crosscuts 87 and 88, there was no perceptible movement of air in either direction. Gov't Ex. 26; Tr. 511. At crosscut

¹¹ An "inch of water" is a unit of pressure equivalent to 0.036136 pounds per square inch ("psi"). Am. Geological Inst., *Dictionary of Mining, Mineral, and Related Terms* 276 (2d ed. 1997).

88, there were airflow quantities of 4,306 cfm entering BEP 30B from the ladders¹² and 4,042 cfm exiting BEP 30 in the No. 2 tailgate entry, indicating that there was no net movement of air in the tailgate portion of the gob. Gov't Ex. 26; Tr. 556, 1129-30. Thus, the methane-air mixture in the back corner of the tailgate was not being continuously diluted and moved away from the worked-out area as required by the standard. Based on these survey results, we believe the judge reasonably concluded that the bleeder system was ineffective.

We reject Cumberland's assertion that the judge erred in finding that the January 16 citation for the ineffective bleeder system was not duplicative of the January 13 citation for failure to comply with the ventilation plan. PDR 18; C. Br. 20-21. The Commission has held that citations are not duplicative so long as the standards involved impose separate and distinct duties upon an operator. *Western Fuels-Utah, Inc.*, 19 FMSHRC 994, 1003-05 (June 1997); *Cyprus Tonopah Mining Corp.*, 15 FMSHRC 367, 378 (Mar. 1993). As the judge recognized, the January 13 and 16 citations allege non-compliance with different duties and are not based on the same acts or omissions. 27 FMSHRC at 313. Additionally, the fact that both citations were abated by the approval of the January 21 ventilation plan does not render them duplicative. As the judge found, different aspects of the January 21 plan addressed the separate deficiencies, i.e., noncompliance and ineffectiveness, that gave rise to the citations. *Id.* Moreover, the judge aptly noted that Cumberland could have abated the January 13 citation by conforming the bleeder system to the December 9 ventilation plan rather than formulating a new plan for MSHA's approval. *Id.* at n.20; see Jt. Ex. 5 at 2 (extending citation "to give the operator additional time to comply with the approved plan or to formulate a new plan and get it approved").

Likewise, we reject Cumberland's assertion that the judge erred in determining that Cumberland's attempt to comply with a ventilation plan was not a defense to the January 16 citation. PDR 18; C. Br. 21. The Commission has previously held that compliance with a mine's roof or dust control plan does not preclude a finding of a violation of the underlying roof or dust control regulations. See, e.g., *Southern Ohio Coal Co.*, 10 FMSHRC 138, 140-41 (Feb. 1988) (concluding that compliance with an approved roof control plan is not controlling for purposes of determining compliance with a roof control regulation); *Utah Power & Light Co.*, 12 FMSHRC 965, 969 (May 1990), *aff'd*, 951 F.2d 292 (10th Cir. 1991) (concluding that compliance with the terms of a dust control plan does not preclude a finding that an operator violated the terms of a dust control regulation). Similarly, an operator cannot avoid a finding of violation of section 75.334(b)(1) by arguing that it was complying with the provisions of its ventilation plan. Rather, an operator is required to comply with ventilation plan provisions, which specify precautions and practices applicable to the particular conditions at a mine, in addition to the more general provisions of section 75.334, which set forth a level of safety required at all mines. See 57 Fed. Reg. 20,868, 20,900 (May 15, 1992). Given that conditions in a mine may change unexpectedly, compliance with specific ventilation plan provisions may not

¹² The ladders are two sets of entries behind LW49. The inner ladder is used to set up the longwall face, and it eventually collapses and becomes part of the gob. The outer ladder is used for ventilation between the headgate and tailgate. Tr. 48, 72-74, 107-09; see Jt. Exs. 1A & 10A.

necessarily assure that the general protections afforded by ventilation regulations are being met. Therefore, Cumberland was required to comply with section 75.334(b)(1) independent of the ventilation plan approval process, and it could be charged with violating the standard even if it was fully complying with its approved ventilation plan. *See Plateau Mining Corp.*, 28 FMSHRC ____, slip op. at 11 & 20 (separate opinions of Comm’rs Young and Jordan), Nos. WEST 2002-207 & WEST 2002-278 (Aug. 22, 2006).

With regard to Cumberland’s argument that it lacked notice of the violation, we recognize that section 75.334(b)(1) is broadly worded and that the concept of “effectiveness” is a general one. As the Commission has previously observed, however, “[m]any standards must be ‘simple and brief in order to be broadly adaptable to myriad circumstances.’” *Alabama By-Prods. Corp.*, 4 FMSHRC 2128, 2129 (Dec. 1982) (quoting *Kerr-McGee Corp.*, 3 FMSHRC 2496, 2497 (Nov. 1981)). Nonetheless, such broad standards must afford reasonable notice of what is required or proscribed. *Alabama By-Prods.*, 4 FMSHRC at 2129. When faced with a challenge that a safety standard fails to provide adequate notice of prohibited or required conduct, the Commission has applied an objective standard, i.e., the reasonably prudent person test. *BHP Minerals Int’l Inc.*, 18 FMSHRC 1342, 1345 (Aug. 1996). The appropriate test “is not whether the operator had explicit prior notice of a specific prohibition or requirement, but whether a reasonably prudent person familiar with the mining industry and the protective purposes of the standard would have recognized the specific prohibition or requirement of the standard.” *Ideal Cement Co.*, 12 FMSHRC 2409, 2416 (Nov. 1990).

Substantial evidence supports the judge’s determination that a reasonably prudent person would have recognized that the bleeder system was not functioning as required by section 75.334(b)(1). As discussed above, MSHA’s survey results indicated that the methane-air mixture in the back corner on the tailgate side of LW49 was not emerging from the inby BEPs. In essence, the back corner of the tailgate was a dead airspace. In view of this fact, we believe that a reasonably prudent person would have recognized that the bleeder system failed to continuously dilute and move the methane-air mixture from the worked-out area away from the active workings.

Based on the foregoing, we conclude that substantial evidence supports the judge’s determination that, on January 16, Cumberland violated section 75.334(b)(1) and that Cumberland had adequate notice that its bleeder system was not functioning as required by the standard. Accordingly, we affirm the judge’s conclusion and his assessment of civil penalty.

B. Order No. 7066999 (February 4, 2004) and Order No. 7067001 (February 7, 2004)¹³

In his decision, the judge concluded that Tolliver did not abuse his discretion in issuing the imminent danger orders on February 4 and 7. 27 FMSHRC at 327. In reaching this

¹³ Commissioner Jordan dissents from Part II.B of this opinion. *See* slip op. at 27.

conclusion, the judge found that “Tolliver did not act solely on the basis of a single excessive methane reading, either on February 4 or 7.” *Id.* Rather, the judge found that Tolliver “considered the presence of excessive methane and unexplained sudden rises in methane in the system as a whole, and reasonably determined that the conditions he encountered on February 4 and 7 presented imminent dangers to miners.” *Id.*

As we explain more fully below, substantial evidence does not support the judge’s determination that Tolliver reasonably concluded that, based on the information available to him at the time he issued the orders, the conditions on February 4 and 7 amounted to imminent dangers. Thus, we conclude that Tolliver abused his discretion.

Section 3(j) of the Mine Act defines “imminent danger” as the “existence of any condition or practice in a coal or other mine which could reasonably be expected to cause death or serious physical harm before such condition or practice can be abated.” 30 U.S.C. § 802(j). The concept of imminent danger is not limited to hazards that pose an immediate danger. *R&P*, 11 FMSHRC at 2163 (citing *Freeman Coal Mining Co. v. Interior Bd. of Mine Op. App.*, 504 F.2d 741 (7th Cir. 1974)); *see also Blue Bayou Sand & Gravel, Inc.*, 18 FMSHRC 853, 858 (June 1996); *VP-5 Mining Co.*, 15 FMSHRC 1531, 1535 (Aug. 1993); *Island Creek Coal Co.*, 15 FMSHRC 339, 345 (Mar. 1993). Rather, “an imminent danger exists when the condition or practice observed could reasonably be expected to cause death or serious physical harm to a miner if normal mining operations were permitted to proceed in the area before the dangerous condition is eliminated.” *R&P*, 11 FMSHRC at 2163 (quoting *Eastern Associated Coal Corp. v. Interior Bd. of Mine Op. App.*, 491 F.2d 277, 278 (4th Cir. 1974) (emphasis omitted)). To support a finding of imminent danger, an inspector must find that “the hazardous condition has a reasonable potential to cause death or serious injury within a short period of time.” *Utah Power & Light Co.*, 13 FMSHRC 1617, 1622 (Oct. 1991). In reviewing an inspector’s finding of imminent danger, the Commission must support the inspector’s finding “unless there is evidence that he has abused his discretion or authority.” *R&P*, 11 FMSHRC at 2164 (quoting *Old Ben Coal Corp. v. Interior Bd. of Mine Op. App.*, 523 F.2d 25, 31 (7th Cir. 1975) (emphasis omitted)).

We conclude that the judge erred in holding that, on February 4 and 7, Inspector Tolliver did not abuse his discretion in issuing the imminent danger orders.

First, the record indicates that Tolliver did not exercise any discretion in concluding that the conditions posed imminent dangers to miners because, prior to his inspections, he received instructions to issue the orders if he found methane in excess of the limits specified in the January 21 plan. Specifically, Tolliver testified that, on January 31, Pete Krosunger, another MSHA inspector, instructed him to write an imminent danger order and a section 75.334(b)(1) citation if he found more than 4.5% methane at any of the monitoring points. Tr. 829-30, 889. Tolliver also testified that, on February 4, Guley gave him the same instructions. Tr. 832-33, 860, 890, 901-02.

Although an inspector must have considerable discretion in issuing imminent danger orders (*R&P*, 11 FMSHRC at 2164), the constraints on discretion arise here from the directives given to Tolliver to issue the orders based on a single criterion. This precluded the inspector from conducting a requisite reasonable investigation of the facts in exercising his discretion. While safety must be the paramount concern, the extraordinary measure of shutting down a mine with a withdrawal order compels safeguards to ensure that an inspector's discretion is not abused. *See, e.g., Island Creek*, 15 FMSHRC at 347-48 (vacating imminent danger orders issued as a result of methane accumulations in a gob area where Secretary failed to meet her burden of proving that it was reasonable for inspectors, based on information available, to conclude that mine conditions constituted imminent danger). Here, MSHA approved the procedures in Cumberland's ventilation plan for de-energizing the longwall and taking corrective actions when methane readings in excess of 4.5% were obtained at any of the monitoring points. *Jt. Ex. 10* at 2; *Tr. 902*. However, based on contrary directions given to him, Tolliver issued the imminent danger orders before Cumberland could take such measures. Tolliver's adherence to prior instructions without additional indicia of a hazardous condition, "which could reasonably be expected to cause death or serious physical harm before such condition . . . can be abated" (30 U.S.C. § 802(j)), clearly amounted to an abuse of his discretion.¹⁴

Second, substantial evidence does not support the judge's finding that "Tolliver did not act solely on the basis of a single excessive methane reading" at crosscut 85 when issuing the imminent danger orders. 27 FMSHRC at 327. In fact, Tolliver explicitly and repeatedly testified that the bases of his imminent danger orders were the elevated methane readings at crosscut 85. *Tr. 847, 854, 887, 891, 902-03, 913, 918*. For instance, when asked why he issued the imminent danger order on February 4, Tolliver's response was "[b]ecause at the 85 crosscut, I had 4.8 on my hand-held detector." *Tr. 847*. Despite a generalized expression of concern for "the safety of the miners," the elevated methane readings provided the sole evidentiary basis for Tolliver's concern.

We also find unavailing the judge's finding that Tolliver's decisions to issue the orders "were grounded more on his bona-fide concerns for, and evaluation of, the safety of miners, than on a mechanical application of instructions related by other inspectors." 27 FMSHRC at 326. The judge attempted to identify additional bases to support Tolliver's imminent danger determinations by pointing to evidence of subsequent readings that Tolliver obtained at the

¹⁴ Tolliver's actions in issuing the orders were also contrary to an MSHA policy that an inspector cannot use section 107(a) orders for "control purposes" in the absence of an imminent danger. 1 MSHA, U.S. Dep't of Labor, *Program Policy Manual*, Sec. 107, at 34 (2003) ("*PPM*"); *see Oral Arg. Tr. 48-49*. Tolliver was instructed that, if he detected methane levels above 4.5%, he was to issue imminent danger orders pursuant to section 107(a) without any further consideration. In doing so, MSHA was using the orders as means to control methane levels in the bleeder system. Even though the *PPM* is not binding on MSHA, we find that its prohibitions are particularly appropriate here where MSHA's instructions removed Tolliver's independent judgment in issuing the imminent danger orders.

monitoring points at crosscut 82 and between crosscuts 73 and 74 as indications of a “rapid rise in methane concentrations” throughout the system. *Id.* However, Tolliver never testified that he considered this evidence in issuing the orders. In fact, Tolliver testified that once he obtained the readings at crosscut 85 in excess of 4.5%, he issued the orders, took bottle samples, and then exited the mine. Tr. 864, 886. The judge even noted that the subsequent readings were obtained by Tolliver on his way out of the mine, *after* he had issued the imminent danger orders. 27 FMSHRC at 326. Thus, they could not have served as a basis for Tolliver’s imminent danger determinations.

The judge also pointed to the “unexplained sudden rises in methane in the system as a whole” as a substantiating reason for Tolliver’s imminent danger determinations. *Id.* at 326, 327. However, Tolliver’s lack of understanding of the conditions throughout the mine at the time he issued the orders in fact undermine his determinations that the conditions on February 4 and 7 amounted to imminent dangers. Tolliver testified that, at the time he issued the orders, he did not know specific conditions in certain areas of the mine. Tr. 851-53, 856-59, 863-64, 878, 881-83, 888, 897, 898, 900, 904, 907-08. For example, as the judge noted, Tolliver admitted that “he did not know, on either [February 4 or 7], whether there were high methane concentrations in the face area,” despite testifying that he was concerned that methane was coming off the gob onto the face. 27 FMSHRC at 325; Tr. 882, 896, 908. Nor did Tolliver inquire as to the cause of the rise in methane level, despite admitting that he overheard miners discuss a curtain adjustment on the headgate. Tr. 858-59, 888, 905-06. Tolliver also testified that he did not know the distance between crosscut 85, where he obtained the elevated methane readings, and the face, where he was concerned about a potential ignition source. Tr. 863-86. Thus, the record evidence as a whole substantially detracts from the judge’s conclusion that Tolliver did not base his orders solely on the methane readings at crosscut 85.¹⁵

Moreover, the evidence refutes Tolliver’s rationale for his imminent danger orders. Contrary to Tolliver’s vague concerns that gob air was coming onto the face, there were no elevated methane readings at the face. Tr. 1380-81, 1522-23, 1581-85, 1621-24, 1642-43, 1744-48. As the judge noted, the “methane levels at all monitoring points declined to acceptable levels” shortly after Tolliver issued the orders and the record indicates that the sudden rise in methane occurred when a curtain on the headgate was adjusted. 27 FMSHRC at 325-26; Tr. 1536, 1741-44, 1749-50. Finally, the record reveals that no additional actions were required to abate the citations and terminate the orders. 27 FMSHRC at 325; Tr. 1744-45. The judge failed to reconcile the foregoing evidence with his conclusion that Tolliver did not abuse his discretion. Tolliver’s stated concerns about a potential explosion and the safety of the miners cannot

¹⁵ We disagree with our dissenting colleague’s contention that the judge credited Tolliver’s testimony that the bases of his imminent danger orders were more than the crosscut 85 readings. Slip op. at 32. Tolliver testified that the readings at crosscut 85 were the sole bases for them (Tr. 891), and our colleague cannot avoid the lack of record support for the judge’s conclusion by labeling his finding as a credibility determination.

overcome this contrary evidence or his lack of knowledge and inquiry, as evidenced by his testimony, of the conditions present at the time he issued the orders.

In sum, because the instructions left Tolliver no discretion to make an independent judgment as to the existence of the imminent dangers and substantial evidence does not support the judge's finding that Tolliver acted on circumstances beyond the elevated methane readings at crosscut 85, we regard his issuance of the orders as abuses of discretion. Our conclusion that Tolliver abused his discretion is limited to the unique circumstances of this case and is based on the Secretary's failure to demonstrate that, based on the information available to Tolliver at the time, it was reasonable for him to conclude that the conditions in the mine constituted imminent dangers. *See Island Creek*, 15 FMSHRC at 347-48.

Based on the foregoing, we conclude that substantial evidence does not support the judge's affirmance of the imminent danger orders. Accordingly, we reverse the judge and vacate Order Nos. 7066999 and 7067001 and the associated civil penalties.

C. Citation No. 7067000 (February 4, 2004) and Citation No. 7067003
(February 7, 2004)

Commissioners are evenly divided regarding whether the judge correctly determined that, on February 4 and 7, the LW49 wraparound bleeder system was not functioning as required by section 75.334(b)(1). Commissioners Jordan and Young would affirm the portion of the judge's decision holding that Cumberland violated section 75.334(b)(1) on February 4 and 7. Chairman Duffy and Commissioner Suboleski would reverse that portion of the judge's decision and vacate the citations. The effect of the split decision is to allow the judge's decision to stand as if affirmed. *See Pennsylvania Elec. Co.*, 12 FMSHRC 1562, 1563-65 (Aug. 1990), *aff'd on other grounds*, 969 F.2d 1501 (3d Cir. 1992). The separate opinions of the Commissioners follow.

III.

Separate Opinions of the Commissioners

Commissioner Young, in favor of affirming Citation Nos. 7067000 and 7067003:

At issue here is whether Cumberland violated 30 C.F.R. § 75.334(b)(1) on February 4 and 7, 2004. The judge below thoroughly considered the record evidence and concluded that the sudden increases in methane, combined with other circumstances present in Cumberland's mine on the operative dates in question, amounted to violations of section 75.334(b)(1). I find no material error of law in the judge's decision. The Commission's role on review is thus limited to determining whether substantial evidence supports the factual findings on which the judge has based his conclusion of the violations. Under this test, the Commission may not "substitute a competing view of the facts for the view [a judge] reasonably reached." *Donovan ex rel. Chacon v. Phelps Dodge Corp.*, 709 F.2d 86, 92 (D.C. Cir. 1983).

Based on the record evidence, I conclude that substantial evidence supports the judge's determination that, on February 4 and 7, the LW49 wraparound bleeder system was not functioning effectively, in violation of section 75.334(b)(1).¹ 27 FMSHRC 295, 323-27 (Mar. 2005) (ALJ). This finding is supported by evidence that sudden increases in methane concentrations at or near the explosive range were detected at the monitoring point at crosscut 85 in the No. 2 tailgate entry. *Id.* at 326-27. In addition, sudden and significant methane increases were detected at other monitoring points along the panel's tailgate side, indicating a build-up of methane in the bleeder system. *Id.* at 325-27, 331.

On February 4, Inspector Tolliver found a significant increase in the methane concentration of the air exiting the BEP 30 regulator. 27 FMSHRC at 326; Gov't Ex. 34. The methane concentration had increased from 2.0% at 12:39 p.m. to 3.0% at 1:22 p.m. *Id.* Tolliver then proceeded to the monitoring point at crosscut 85 where he found that the methane concentration of air flowing out of the sampling tube² had increased from 3.0% at 12:37 p.m. to 4.8% at 1:25 p.m., a level that exceeded the 4.5% limit specified in the January 21 plan. 27 FMSHRC at 324, 326; Gov't Ex. 34; Jt. Exs. 10 & 10A; Tr. 847-48, 945-48. While there is some question about the accuracy of Tolliver's methane reading, the judge's conclusion that it was supported by comparable measurements obtained by Cumberland and UMWA personnel using their handheld detectors is not inherently unreasonable. *See* 27 FMSHRC at 324; Tr. 847-48, 892, 917-18, 943-48, 960 (the measurements were taken twice and the detectors differed no more than three to four tenths). Tolliver took two bottle samples, then issued the imminent danger order and citation, shutting down production. Tr. 209, 849-66, 918-19, 948-49. After Tolliver issued the imminent danger order, and as he exited the mine, he took additional measurements and found that methane at the monitoring point at crosscut 82 had increased from 3.3% at 12:35 p.m. to 4.4% at 1:30 p.m., methane at BEP 30A had increased from 1.1% at 12:25 p.m. to 1.6% at 1:35 p.m., and methane at the monitoring point in the No. 1 tailgate entry between crosscuts 73 and 74 had increased from 1.8% at 12:20 p.m. to 2.1% at 1:40 p.m. 27 FMSHRC at 326; Gov't Exs. 18 & 34.

On February 7, Tolliver experienced a similar situation. 27 FMSHRC at 326; Tr. 869. Methane levels at the various monitoring points were relatively steady and within acceptable limits, with the exception of the monitoring point between crosscuts 73 and 74, which was fluctuating in the 2.0% range and causing interruptions to production. 27 FMSHRC at 326; Gov't Ex. 20; Tr. 870. At approximately 10:00 a.m., however, methane levels began to climb

¹ Unlike our review of the imminent danger orders (slip op. at 10-14), the standard of review of a section 104(a) citation is grounded solely on the conditions as they existed — i.e., whether substantial evidence supports the judge's finding of a violation based on the record evidence — not on the inspector's knowledge or discretion.

² Tolliver's readings were taken through a tube installed approximately 1 foot from the roof rather than through the pipe installed approximately 3 feet from the floor. *See* Tr. 593-602; Gov't Exs. 18 & 20.

dramatically. 27 FMSHRC at 326; *see* Gov't Ex. 20 (showing methane increasing at crosscuts 82 and 85 and BEPs 30 and 30B). At 12:20 p.m., Tolliver measured a methane concentration of 5.0% flowing out of the sampling tube at crosscut 85, a substantial increase over the previous reading of less than 3.0% approximately 2 hours earlier and a level that exceeded the 4.5% limit specified in the January 21 plan. 27 FMSHRC at 326; Gov't Exs. 6, 7, 20, & 35; Jt. Exs. 10 & 10A; Tr. 871-72, 875, 953. The judge again found that Tolliver's methane reading was consistent with readings taken by accompanying Cumberland and UMWA personnel, who obtained comparable measurements using their handheld detectors. 27 FMSHRC at 325; *see* Tr. 871-72, 874, 917-18, 952-55 (the measurements were taken twice and the detector readings were "about the same" and "pretty close"). Tolliver took bottle samples and then issued the imminent danger order and citation. 27 FMSHRC at 325; Tr. 873-88. At 12:35 p.m., Tolliver also measured a methane concentration of 4.1% at BEP 30B. Tr. 903-05, 965-66.

Moreover, Tolliver testified that on February 4, when he "hit this spike . . . or this slug [of methane] at 85 crosscut, [he] knew that something had happened" and he was "afraid . . . that the gob air might be coming on the face air on the longwall." 27 FMSHRC at 324-26; Tr. 851-52; *see also* Tr. 949-50, 965-66 (similar concerns of Jeffrey Mihallik, UMWA safety committee member). Tolliver explained that he "didn't think they had enough positive pressure on the gob to carry away the methane on the back." Tr. 856-57. He considered the amount of methane detected at crosscut 85 as an indication that the bleeder system "wasn't working properly" and that it was "not effective." Tr. 856, 858. Once more, on February 7, Tolliver was concerned by the rapid increase in methane concentrations, stating that he was "afraid the methane was coming off the gob, going to the active longwall face" because he thought "there wasn't enough pressure on the back side." 27 FMSHRC at 326; Tr. 878, 881; *see also* Tr. 955, 959, 965-66 (similar concerns of Mihallik). Again, Tolliver considered the high methane concentration as an indication that the bleeder system was "ineffective." Tr. 880-81, 883.

Likewise, the testimony of MSHA's expert, John Urosek, also supports the judge's determination that the bleeder system was ineffective on February 4 and 7. According to Urosek, the size of the gob had increased due to continued mining and the bleeder system had become more fragile and incapable of handling methane liberation. Tr. 1150, 1155. Urosek opined that the sudden increases in methane, in conjunction with the airflow changes caused by the adjustment or movement of curtains on the headgate, indicated that methane was "sitting in the internal air flow paths" of the gob, extending "all the way to the face." 27 FMSHRC at 325; Tr. 1150-52, 1155-56. Urosek stated, "we don't know what the pressure differentials were" across the longwall face and into the tailgate entries, but "[w]e know that they were insufficient to cause the air flow to move in the proper direction to dilute the methane."³ Tr. 1232-34, 1247-48, 1256-57. Urosek explained that "the inadequate pressure differentials, and therefore the low air

³ The only readings known on February 4, were an airflow quantity of 15,876 cfm and a pressure differential of 0.25 inches of water at BEP 30B (Tr. 895), and on February 7, an airflow quantity of 15,120 cfm and a pressure differential of 0.25 inches of water at BEP 30B (Tr. 903-04). *See* C. Post-Hearing Br. 46 n.22; PDR 23; C. Br. 30 (correcting transcript to read "0.25").

flows . . . allowed that methane to stay very close to that longwall face, so changes, inadvertent or on purpose, that occur somewhere in the system could allow that methane to come on the longwall face.” Tr. 1248-49. The judge appears to have credited Urosek’s testimony over that of Cumberland’s witnesses who did not believe that methane was backing up to the face because there were no high methane readings at the face and the pressure differentials and airflows were away from the face toward the back of the gob. *See* 27 FMSHRC at 325, 327 (citing Tr. 1380-81, 1522-23, 1581-85, 1621-24, 1642-43, 1744-48). Based on the testimony of MSHA’s expert, the judge could thus reasonably conclude that the bleeder system was not effectively diluting and moving methane away from the active workings.

The record also indicates that shortly after Tolliver issued the orders and citations on February 4 and 7, methane levels at all the monitoring points decreased to acceptable levels, and production resumed each evening. 27 FMSHRC at 325-26; Gov’t Ex. 18. In both instances, the increase in methane was temporarily caused by the adjustment of a ventilation curtain on the headgate side of LW49. 27 FMSHRC at 325; Tr. 858-59, 905, 951, 958, 1536, 1741-45. Nevertheless, even a minor adjustment can have a significant impact, as evidenced by the facts here, where the margin between acceptable levels of methane and highly dangerous explosive levels of methane was so narrow. This is particularly significant considering the fragile nature of Cumberland’s bleeder system and the challenging mine environment. 27 FMSHRC at 302. Cumberland’s mine was identified as a gassy mine subject to spot inspections every 5 days pursuant to section 103(i) of the Mine Act, 30 U.S.C. § 813(i), and had been having significant problems with its wraparound bleeder system. 27 FMSHRC at 298-99. All of these factors could reasonably be construed as showing that the bleeder system was incapable of continuously diluting, rendering harmless, and carrying away increased levels of methane entering the system.

On appeal, Cumberland attempts to raise as a defense that it did not have adequate notice that MSHA would rely on the readings it obtained at locations other than BEPs, such as the No. 2 tailgate entry which effectively was part of the gob, to evaluate the bleeder system. PDR 14-15; C. Br. 14-17; C. Reply Br. 13. However, the defense is unavailable here. Cumberland’s January 21 ventilation plan clearly designated numerous locations within the bleeder system, including the locations at issue here, as monitoring points where data was to be collected. 27 FMSHRC at 302-03; Jt. Exs. 10 & 10A. While the ventilation plan merely identified action levels, rather than set absolute limits for methane at all designated monitoring points, it is reasonable to expect that MSHA would use the data collected at these points to evaluate the bleeder system. Indeed, that was the point of the additional monitoring locations. As MSHA’s Assistant District Manager Thomas Light testified, the evaluation point at crosscut 85 was necessary because the original evaluation point at BEP 30 “didn’t actually give us any indication of what was happening on this tailgate side of the bleeder system . . . so in effect, we weren’t evaluating the bleeder system [using BEP 30].” Tr. 167. Light further testified that the evaluation points are established “based on what is actually necessary to evaluate the adequacy of the system.” Tr. 168. MSHA Inspector Ronald Hixson and expert witness John Urosek also testified about the need for the additional evaluation points, including the point at crosscut 85. Tr. 743-45, 1260-61. If continuous effectiveness is, as we have held, a requirement for all bleeder systems, Cumberland

cannot assert that it lacked notice when monitoring points established by MSHA to evaluate system effectiveness (with the operator's acceptance) were, in fact, used to determine whether the bleeder system was operating effectively.⁴

In this case, the data collected adequately support the judge's finding that the system was not effectively diluting and carrying away methane on February 4 and 7.⁵ Because Cumberland

⁴ My colleagues confuse the notice question by focusing on whether Cumberland received adequate notice "regarding how the new data [obtained at crosscut 85] would be used for enforcement purposes" and whether "MSHA officials had informed Cumberland that they believed an excessive reading at crosscut 85 would constitute a violation of the standard." Slip op. at 24, 25. However, the readings at crosscut 85 were but one of several indicia of the system's ineffectiveness which the judge found in support of the violations. Moreover, the Commission has not required that an operator receive actual notice of the Secretary's interpretation of a cited standard. Rather, the Commission has applied, as my colleagues acknowledge (slip op. at 23-24), an objective standard of notice, i.e., the reasonably prudent person test. *E.g., Otis Elevator Co.*, 11 FMSHRC 1896, 1906 (Oct. 1989), *aff'd*, 921 F.2d 1285, 1292 (D.C. Cir. 1990); *Alabama By-Products Corp.*, 4 FMSHRC 2128, 2129 (Dec. 1982). As discussed above, Cumberland reasonably would have known that MSHA would rely upon the methane readings obtained at the additional monitoring points, including crosscut 85, to determine whether its bleeder system was operating effectively.

Furthermore, while Cumberland could have refused to adopt what it and my colleagues have characterized as an "unprecedented" monitoring of the gob (Oral Arg. Tr. 5; slip op. at 21), and then challenged the citation, it instead faxed to MSHA its revised ventilation plan including the provision it now challenges on notice grounds. Tr. 169 (Hixson testified that MSHA received the plan by fax and a phone call agreeing to the stipulations required).

⁵ The evidentiary threshold for proving a ventilation system is ineffective under section 75.334(b)(1) varies significantly from the burden required to establish that the violation amounts to an imminent danger. *See* 30 U.S.C. § 802(j) ("imminent danger" means the existence of any condition or practice in a coal or other mine which could reasonably be expected to cause death or serious physical harm *before such condition or practice can be abated*" (emphasis added)); *Utah Power & Light Co.*, 13 FMSHRC 1617, 1622 (Oct. 1991) (to support a finding of imminent danger, an inspector must find that "the hazardous condition has a *reasonable potential to cause death or serious injury within a short period of time*" (emphasis added)). In particular, intermediate measures which might address a bleeder system's ineffectiveness, including adjustments to the system and suspension of production, would not sufficiently ameliorate the hazard of an imminent danger found by an inspector so as to prevent serious injury or death to miners. While I conclude that the record here supports the judge's findings of the section 75.334(b)(1) violations, as noted previously (*supra*, slip op. at 11), the record cannot sustain the conclusion that the inspector reasonably applied his discretion and considered the facts known or available to him upon reasonable investigation to determine that the conditions amounted to an

was able to negotiate its ventilation plan with MSHA through the plan approval process, Cumberland can be held to both know the content of the plan and be bound by its provisions. Thus, it is neither unfair nor inappropriate for MSHA to rely upon readings taken at designated monitoring points in the No. 2 tailgate entry to determine whether the bleeder system was functioning as required. Accordingly, I conclude that Cumberland had adequate notice here.⁶

In sum, I believe that substantial evidence supports the judge's findings that, on February 4 and 7, there were sudden and significant increases in methane concentrations along the tailgate side of LW49, particularly at the monitoring point at crosscut 85, indicating a build-up of methane in the bleeder system. Based on the circumstances in this case, the judge correctly determined that, on both dates, Cumberland violated section 75.334(b)(1) because its bleeder system failed to effectively dilute and move methane away from the active workings.

For the foregoing reasons, I would affirm the judge's decision regarding the February 4 and 7 citations.

Michael G. Young, Commissioner

imminent danger.

⁶ I reject Cumberland's argument that it cannot be cited for violating section 75.334(b)(1) because it was in compliance with its January 21 ventilation plan. PDR 18-19; C. Br. 23. As discussed *supra*, Cumberland's duty to comply with the ventilation plan and its duty to have an effective bleeder system are separate and distinct and section 75.334(b)(1) can be enforced irrespective of ventilation plan requirements. *See* 27 FMSHRC at 312 n.19.

Chairman Duffy and Commissioner Suboleski, in favor of reversing and vacating Citation Nos. 7067000 and 7067003:

We disagree with our colleagues' determination to affirm the judge's ruling upholding the citations issued to Cumberland on February 4 (Citation No. 7067000) and February 7 (Citation No. 7067003) and would reverse that portion of the judge's decision. Although we agree with our colleagues that Cumberland violated 30 C.F.R. § 75.334(b)(1) on January 16, our review of the record indicates that the circumstances surrounding the February 4 and 7 citations are significantly different from those on January 16. We dissent on two separate grounds. The judge's determination that Cumberland violated section 75.334(b)(1) on February 4 and 7 is not supported by substantial evidence, and, in any event, Cumberland was not provided sufficient notice concerning what constituted a violation of the standard and how certain data would be used by MSHA for enforcement purposes.

 A. Substantial Evidence

We conclude that there is not substantial evidence to support the conclusion that Cumberland's ventilation system was ineffectively diluting and removing methane from Longwall Panel No. 49 on February 4 and 7. Rather, the evidence shows only that certain action levels in Cumberland's revised ventilation plan had been triggered — action levels that required production to cease temporarily. As explained below, MSHA's citations were based on an unprecedented theory of measuring methane levels within the gob itself to allege that a ventilation system was not functioning effectively.

At the outset, it is highly significant that the judge never directly addressed in any detail the specific issue of whether the conditions on February 4 and 7 constituted a violation of section 75.334(b)(1). Instead, the judge focused on the separate issue of whether the inspector's issuance of imminent danger orders on those dates should be upheld and concluded that the inspector "did not abuse his discretion" in issuing the imminent danger orders. 27 FMSHRC 295, 325-27 (Mar. 2005) (ALJ). Without further discussion, he then summarily stated that: "For the reasons stated above, I find that the bleeder system was ineffective on February 4 and 7, as alleged in Citation Nos. 7067000 and 7067003. It was not effectively ventilating the area within the bleeder system and protecting the active workings from hazardous methane accumulations." *Id.* at 327. However, facts that would justify the issuance of an imminent danger order might or might not establish that section 75.334(b)(1) had been violated. The latter issue involves a separate inquiry. *See Utah Power & Light Co.*, 13 FMSHRC 1617, 1622 (Oct. 1991) (imminent danger orders can be issued regardless of whether the Mine Act or the Secretary's regulations have been violated). Thus, the judge's failure to adequately discuss the evidence that he believed established violations of section 75.334(b)(1) on February 4 and 7 apart from the imminent danger orders would require, at the very least, a remand. *Mid-Continent Res., Inc.*, 16 FMSHRC 1218, 1222-23 (June 1994) (remand is appropriate when judge fails to adequately address evidentiary record and explain reasons for decision).

Moreover, our decision to vacate the February 4 and 7 imminent danger orders in this case seriously calls into question the judge's conclusion that the Secretary met her burden of proving that section 75.334(b)(1) was violated on those same dates. In Part II.B of this opinion, a majority of the Commission concludes that substantial evidence does not support the judge's decision to uphold the February 4 and 7 imminent danger orders and that the inspector abused his discretion in issuing the orders. Slip op. at 10-14. The majority holds that Inspector Tolliver improperly exercised his discretion because he had been instructed by other inspectors to issue imminent danger orders for any methane readings that exceeded any monitoring limits in Cumberland's revised January 21 ventilation plan. 27 FMSHRC at 324; *see* slip op. at 11-12. Just as the inspector was directed to issue imminent danger orders if readings exceeded 4.5% at crosscut 85, he was likewise directed to issue citations for those same readings. *Id.* Accordingly, it is unclear to what extent the inspector exercised independent judgment in charging that the ventilation system was functioning ineffectively in violation of section 75.334(b)(1).

In deciding whether the conditions at Cumberland's mine on February 4 and 7 constituted a violation of section 75.334(b)(1), it is important to recognize what Inspector Tolliver did *not* find. The inspector did not find any indication that the system was failing to continuously dilute and move air away from the active workings. He did not find that methane levels had reached action levels at any of the BEPs.¹ He did not find an excess level of methane in the travelable bleeder entries. He did not find weak air flow in the gob. He did not find that there were high readings at the face or that any alarms at the face had been triggered. 27 FMSHRC at 325; Tr. 882, 896, 908. Finally, he did not find that the air was moving in the wrong direction in any of the entries or in the gob.

Although all the factors outlined above would indicate that the system was functioning effectively, MSHA nevertheless issued the two citations in question based on readings taken in the gob itself. This unprecedented approach raises serious problems. The inspector took methane readings at monitoring pipes that had been installed at MSHA's insistence in crosscut 85, which is clearly located in the dilution zone of the gob. It is undisputed that methane levels will pass through the explosive range (5% to 15%) within the dilution zone of the gob. Indeed, the Secretary's own witnesses testified that the gob may contain air with methane mixtures anywhere between 0% and 100% and that the gob is expected to have regions in which explosive methane levels will be found. Tr. 709-10, 1031-32, 1219, 1225. Methane levels in the gob itself have never been a basis for citing an operator for violating ventilation standards. *See Island Creek Coal Co.*, 15 FMSHRC 339, 350 (Mar. 1993) ("If the Secretary believes that specific accumulations of methane create a hazard in gobs or other inactive areas of underground coal mines, he should consider promulgating safety standards to deal with this problem."). The proper test of whether a ventilation system is functioning effectively is whether an adequate quantity of air continues to move in the right direction and whether the air is adequately diluted by the time it reaches the BEPs and enters the travelable bleeder entries. *See RAG Cumberland*

¹ Indeed, the inspector apparently did not even attempt to take a subsequent reading at BEP 30 or BEP 30B after detecting a methane reading of 4.5% at crosscut 85.

Res. LP, 26 FMSHRC 639, 648-51 (Aug. 2004), *aff'd sub nom. Cumberland Coal Res., LP v. FMSHRC*, No. 04-1427, 2005 WL 3804997 (D.C. Cir. Nov. 10, 2005) (ventilation system was ineffective where air quantities were inadequate and high methane readings were occurring in travelable bleeder entries).

The judge seems not to have fully comprehended the critical fact that the high methane readings on February 4 and 7 took place, not in a travelable bleeder entry or at a designated BEP, but in the gob — an area in which the presence of explosive methane mixtures was not unexpected or contrary to any regulation. Indeed, the judge's opinion contains no explanation of his rationale for relying upon the gob readings at crosscut 85 in upholding the February 4 and 7 citations. The readings in crosscut 85 may have been a warning to watch for high methane levels at the BEPs and travelable bleeder entries and, by the terms of the revised ventilation plan, they required that power to the face be cut off.² However, they did not establish that the system was ineffective — particularly given the fact that all other readings indicated that the system was functioning effectively. There is no evidence to show that there was insufficient air volume to dilute methane below the required level at the BEPs.

Although the judge also relied on increases in methane levels that took place at other monitoring points within the tailgate entry to support the imminent danger orders (27 FMSHRC at 326-27), those increases are not sufficient to conclude that the ventilation system itself was failing. First, while the judge found that the inspector did not act solely on the basis of a single high methane reading in crosscut 85 on each day, we have already concluded, in vacating the February 4 and 7 imminent danger orders, that this finding is not supported by substantial evidence. Slip op. at 12-14. Second, methane fluctuations in the gob are to be expected and can be caused by a number of sources. Indeed, the short-duration increases in readings in the tailgate entries were caused by specific events. On both February 4 and 7, the increases were preceded by the adjustment of a ventilation curtain in a headgate entry. Transitory increases in readings following such events would not be unexpected. Because the inspector was instructed by his supervisors to issue a citation if the reading at crosscut 85 in the gob exceeded 4.5%, the inspector failed to make an overall assessment of the ventilation system to determine whether it was functioning effectively. Although the inspector cited indications of methane fluctuations in

² MSHA had insisted that Cumberland install the pipes in crosscut 85 after Cumberland was cited for violating section 75.334(b)(1) on January 16. 27 FMSHRC at 302. The January 21 revised ventilation plan provides that a methane reading exceeding 4.5% at certain monitoring points, including the one in crosscut 85, "will cause power to be deenergized on the longwall face and immediate corrective action to be taken." Jt. Ex. 10. Although the revised ventilation plan called for the pipes to be installed, the plan does not provide that a reading exceeding 4.5% at crosscut 85 indicates that the system is functioning ineffectively or that section 75.334(b)(1) has been violated.

the gob, he did not otherwise establish that air quantities were inadequate, that airflow was reversed, or that the critical measurements at the BEPs exceeded permissible levels.³

For the reasons set forth above, we conclude that the judge's decision to uphold the February 4 and 7 citations is not supported by substantial evidence. Given all the indications that the system was functioning effectively on those dates, the readings within the gob itself and transitory increases in readings at certain other monitoring points do not provide a sufficient basis for concluding that Cumberland's ventilation system was failing to effectively dilute and move methane away from the active workings on February 4 and 7.

B. Notice

We further conclude that the February 4 and 7 citations should also be vacated because MSHA did not provide adequate notice to Cumberland as to how it would interpret and apply the standard and the January 21 revised ventilation plan, and what criteria it would use in issuing citations. In particular, MSHA took the unprecedented approach of relying on methane readings in the gob to charge that section 75.334(b)(1) was being violated.

We note that the judge's opinion did not address at all Cumberland's arguments below that it was denied fair notice with regard to the February 4 and 7 citations. Although the judge did address the question of notice in connection with the January 16 citation (27 FMSHRC at 313-15), that discussion does not resolve the notice issue for the February 4 and 7 citations. In particular, resolution of the notice issue hinges in large part on certain provisions in the January 21 revised ventilation plan and MSHA's new policy regarding how those provisions would be used for enforcement purposes. Accordingly, because the judge never addressed the notice issue for the February 4 and 7 citations, at the very least, a remand of the notice issue would be necessary.

To avoid due process problems stemming from an operator's asserted lack of notice, the Commission has adopted an objective measure (the "reasonably prudent person" test) to determine if a condition is violative of a broadly worded standard. That test provides:

[T]he alleged violative condition is appropriately measured against the standard of whether a reasonably prudent person familiar with the factual circumstances surrounding the allegedly hazardous

³ Our colleagues also contend that the testimony of MSHA's expert witness, John Urosek, supports the judge's determination that the ventilation system was ineffective on February 4 and 7. Slip op. at 16-17, 32-33. However, while the judge noted Urosek's testimony in discussing the imminent danger orders (27 FMSHRC at 325), he did not purport to rely upon it for any purpose. In any event, the judge could have relied upon Urosek's testimony only if he had also discussed and weighed the directly countervailing testimony of three of Cumberland's witnesses (Robert Kimutis, Robert Bohach, and John Dzurino). *See id.*

condition, including any facts peculiar to the mining industry, would recognize a hazard warranting corrective action within the purview of the applicable regulation.

Alabama By-Products Corp., 4 FMSHRC 2128, 2129 (Dec. 1982); *see also Asarco, Inc.*, 14 FMSHRC 941, 948 (June 1992). As the Commission stated in *Ideal Cement Co.*, 12 FMSHRC 2409, 2416 (Nov. 1990), “in interpreting and applying broadly worded standards, the appropriate test is not whether the operator had explicit prior notice of a specific prohibition or requirement,” but whether a reasonably prudent person would have ascertained the specific prohibition of the standard and concluded that a hazard existed. The Commission has explained that

the reasonably prudent person test must be based on conclusions drawn by an objective observer with knowledge of the relevant facts. It follows that the facts to be considered must be those which were reasonably ascertainable prior to the alleged violation. Moreover, the test must be applied based on the totality of the factual circumstances involved, not just those which tend to favor one party or the other.

U.S. Steel Mining Co., 27 FMSHRC 435, 439 (May 2005) (citations omitted).

Application of the reasonably prudent person test here demonstrates that such an objective observer would *not* have concluded that the ventilation system for LW49 was functioning ineffectively within the meaning of section 75.334(b)(1) on February 4 or 7. As explained above with regard to whether violations of the standard occurred on those dates, the reasonably prudent person would have been aware of the fact that all the principal indicators showed that the ventilation system was effectively diluting and moving methane away from the working section. Methane levels at all the BEPs were in the acceptable range. Methane levels in the travelable bleeder entries were in the acceptable range.⁴ There was not weak air flow in the gob. No alarms at the face had been triggered. Air was not moving in the wrong direction. Although the reading in excess of 4.5% at crosscut 85 in the gob required, under the revised plan, that the face be deenergized, this would not have indicated that the system itself was ineffective. In a gassy mine such as this, ceasing production after such an action level is reached is not at all unusual. Nothing in the revised plan provided that triggering the action level constituted a violation of the standard, and there was no evidence that MSHA officials had informed Cumberland that they believed an excessive reading at crosscut 85 would constitute a violation of the standard.

⁴ We note that, downstream of the longwall face at the monitoring point between crosscuts 73 and 74, the methane levels fluctuated around the 2% level. Gov’t Exs. 18 & 20. However, this is indicative of inadequate dilution in meeting the 30 C.F.R. § 75.323(e) standard and not indicative of a violation of section 75.334(b)(1).

Similarly, transitory increases in certain readings in the tailgate entries would not have indicated that the system was functioning ineffectively. The reasonably prudent mine operator would have inquired into the cause of the rise in methane levels and become aware that ventilation curtains in the headgate entries had been adjusted shortly before the increases. The high reading at crosscut 85 and the momentary increases in the tailgate entries would have simply alerted a reasonably prudent mine operator that readings at the face, the BEPs, and the travelable bleeder entries should be closely watched to determine if those readings would reach their action levels. The evidence indicates that they did not. *In short, a reasonably prudent mine operator, aware of the relevant facts on February 4 and 7, would not have concluded that the system was functioning ineffectively.* It follows that Cumberland did not have adequate notice of what MSHA believed constituted a violation of section 75.334(b)(1) and what conduct MSHA expected from it.

Our colleagues argue that Cumberland cannot raise lack of notice as a defense here because the January 21 revised ventilation plan designated certain locations within the bleeder system, including crosscut 85, as monitoring points where data would be collected. According to them, “[w]hile the ventilation plan merely identified action levels [for those new monitoring points], rather than set absolute limits for methane at all designated monitoring points, it is reasonable to expect that MSHA would use the data collected at these points to evaluate the bleeder system.” Slip op. at 17.

We strongly disagree. Despite the fact that MSHA insisted that the new monitoring points be included in the revised ventilation plan, there is no evidence — in the language of the plan or elsewhere — that MSHA provided notice to Cumberland regarding how the new data would be used for enforcement purposes. Cumberland could reasonably expect that the data — including methane readings from the gob itself — would be used to gauge generally how well the wraparound bleeder system was doing after certain modifications. It could also reasonably expect that, if the action levels in the gob were triggered, MSHA would look at the ventilation system for LW49 in its totality to determine if the system was functioning effectively and that the determination would be based on the traditional indicators — methane readings at the BEPs, in the travelable bleeder entries, and at the face as well as measurements of air quantities and direction. Cumberland could not reasonably expect that MSHA would be taking the unprecedented approach of treating high methane readings in the gob itself as violating its regulations and that the new monitoring points would be used primarily as enforcement weapons.

More specifically, the problem of lack of notice is heightened here by the fact that MSHA’s internal policy was apparently to use readings above 4.5% from crosscut 85 as a sufficient basis for issuing citations to Cumberland for violating section 75.334(b)(1). Inspector Tolliver was instructed to issue a citation if the 4.5% level was exceeded. 27 FMSHRC at 324. In other words, an excessive reading from crosscut 85 would apparently not be just one factor to be considered in determining whether the ventilation system was functioning effectively; instead,

MSHA would treat such a reading as a *per se* violation of the standard.⁵ This indicates that not only was Cumberland not given proper notice of MSHA’s interpretation of the standard and plan provisions, but that Cumberland may have been affirmatively misled by MSHA regarding the reasons why the new monitoring points were being required.⁶

Because MSHA was changing its long-standing policy regarding how methane readings from within the gob itself would be used for enforcement purposes, it was incumbent upon the agency to advise Cumberland of the policy change *before* taking enforcement action. “Those regulated by an administrative agency are entitled to ‘know the rules by which the game will be played.’” *Alaska Professional Hunters Ass’n v. FAA*, 177 F.3d 1030, 1035 (D.C. Cir. 1999) (additional rulemaking was necessary where an agency’s new interpretation of a regulation conflicted with the long-standing interpretation given to it by local agency officials).

In short, when MSHA decided to issue citations for methane levels in the gob rather than at the bleeder entries and BEPs, Cumberland was entitled to notice of the change in the interpretation and application of the standard and the ventilation plan. We would vacate the February 4 and 7 citations for lack of notice.

For the foregoing reasons, we would reverse the judge’s decision regarding Citation Nos. 7067000 and 7067003 and vacate the citations and the associated penalties.

Michael F. Duffy, Chairman

Stanley C. Suboleski, Commissioner

⁵ Indeed, as a majority of the Commissioners has held in this case, “substantial evidence does not support the judge’s finding that ‘Tolliver did not act solely on the basis of a single excessive methane reading’ at crosscut 85 when issuing the [February 4 and 7] imminent danger orders.” Slip op. at 12.

⁶ Cumberland had agreed to MSHA’s provision to cut power to the section when methane levels exceeded 4.5% at the gob monitoring points. There is no indication that Cumberland was aware that the monitoring points would be used for any other purpose.

Commissioner Jordan, in favor of affirming Citation Nos. 7067000 and 7067003 and Order Nos. 7066999 and 7067001:

I agree that substantial evidence supports the judge's determination that on January 16, Cumberland violated 30 C.F.R. § 75.334(b)(1) because its bleeder system failed to effectively dilute and move methane away from the active workings. I also concur with Commissioner Young's analysis and conclusion affirming the portion of the judge's decision holding that Cumberland violated section 75.334(b)(1) on February 4 and 7.¹ However, I dissent from the majority's decision to reverse the judge and vacate the imminent danger orders issued on those dates.

Section 3(j) of the Mine Act defines "imminent danger" as the "existence of any condition or practice in a coal or other mine which could reasonably be expected to cause death or serious physical harm before such condition or practice can be abated." 30 U.S.C. § 802(j). To support a finding of imminent danger, an inspector must conclude that "the hazardous condition has a reasonable potential to cause death or serious injury within a short period of time." *Utah Power & Light Co.*, 13 FMSHRC 1617, 1622 (Oct. 1991). In reviewing an inspector's finding of imminent danger, the Commission must support the inspector's determination "unless there is evidence that he has abused his discretion or authority." *Rochester & Pittsburgh Coal Co.*, 11 FMSHRC 2159, 2164 (Nov. 1989) (quoting *Old Ben Coal Corp. v. Interior Bd. of Mine Op. App.*, 523 F.2d 25, 31 (7th Cir. 1975) (emphasis omitted)). The Commission has held that an "abuse of discretion" is found when "there is *no evidence* to support the decision or if the decision is based on an improper understanding of the law." *Energy West Mining Co.*, 18 FMSHRC 565, 569 (Apr. 1996) (citations omitted and emphasis added) (affirming the judge's determination that the inspector did not abuse his discretion when he issued an order extending abatement time).

Substantial evidence supports the judge's determination that MSHA Inspector Ronald Tolliver exercised appropriate discretion when he issued imminent danger orders on February 4 and 7. 27 FMSHRC 295, 323-27 (Mar. 2005) (ALJ). The judge found that Tolliver's actions were based on his detection of sudden and significant increases in methane concentrations at crosscut 85 and other locations along the tailgate side of Longwall Panel No. 49 ("LW49"). This indicated to the inspector that methane might be moving toward the active longwall face. *Id.* at 326-27.

My colleagues contend the judge's conclusion is without adequate support. They claim that when Tolliver issued the imminent danger orders he "lack[ed an] understanding of the conditions throughout the mine." Slip op. at 13. They fault the inspector for failing to thoroughly investigate numerous conditions at the mine, including the distance to the face from where the methane was measured along the tailgate. *Id.* Detecting elevated methane levels is not sufficient for the majority; they would have the inspector determine the cause of the elevated

¹ I do not concur with footnotes 1 and 5 of Commissioner Young's separate opinion.

methane before taking action. My colleagues consider Tolliver's rationale for issuing the imminent danger orders as little more than "vague concerns that gob air was coming onto the face." *Id.*

However, Tolliver's actions must be viewed against the backdrop of Cumberland's efforts to get its ventilation plan approved. Cumberland initially planned to ventilate LW49 with a bleeder fan system; however the bleeder shaft was not operational when the longwall was ready for production. 27 FMSHRC at 297. In order to avoid a shutdown Cumberland had to resort to another method of ventilation. The operator decided upon a wraparound bleeder system and submitted a plan to MSHA for approval of that design. *Id.* In December 2003, MSHA approved Cumberland's plan, but limited approval to the first 8,000 feet of mining. *Id.* at 297-98.

The following month, while conducting a section 103(i) spot inspection,² MSHA determined that Cumberland was not mining in accordance with the approved ventilation plan. *Id.* at 299. In certain locations airflow was in a direction opposite from what had been approved. Tr. 140-42, 152-54. At the longwall face, they measured air velocity and quantity significantly less than what had been reported in the books (77,000 cfm vs. 40,000-50,000 cfm). Tr. 345. Furthermore, the inspectors encountered conditions, such as low air flows and higher than expected methane concentrations, that signaled an inadequate bleeder system. 27 FMSHRC at 300-01.

Also during January, MSHA became concerned about insufficient ventilation pressures in LW49 that would allow gob air (from the worked-out area) to move toward the longwall face. *See* Tr. 511-12; Gov't Exs. 25 & 26. Sufficient pressure is necessary to move methane located behind the longwall shields away from the longwall face because certain events, such as a roof fall behind the shields, can force gob air into the face area, carrying methane with it. Tr. 1249.

MSHA conducted a ventilation survey³ and confirmed that the bleeder system was fragile and not effectively ventilating the gob of the longwall panel. 27 FMSHRC at 301-02; Tr. 162-63, 503-05; Gov't Exs. 25 & 26. Cumberland agreed not to operate the longwall until the ventilation problems were resolved. 27 FMSHRC at 302.

² Section 103(i) of the Mine Act applies to certain gassy mines and requires MSHA to conduct spot inspections every 5 days at irregular intervals. 30 U.S.C. § 813(i).

³ Approximately seven teams, consisting of three or four people each, participated in the survey. The teams collected information about the bleeder system by taking altimeter readings to determine the ventilating pressures, anemometer readings to determine airflow velocities, pressure gauge readings to determine pressure differentials, smoke tube readings to determine airflow directions and airflow velocities for specific distances, and methane readings using handheld detectors and bottle samples. 27 FMSHRC at 301; Jt. Stip. 27; Jt. Ex. 7; Tr. 87-88, 466-67, 471-81, 487.

Over the next 4 days, MSHA conducted two additional ventilation surveys, concluding each time that despite improvements, the system remained fragile and its capacity to dilute methane was limited. *Id.* On January 21, Cumberland submitted and MSHA approved a new ventilation plan, which included certain additional monitoring points that MSHA had required. *Id.* at 302-03; Jt. Exs. 10 & 10A. Although MSHA approved the plan, it remained concerned about the system's ability to continuously dilute and remove methane from the worked-out areas. 27 FMSHRC at 302. Indeed, the agency's concern was such that, when production resumed, MSHA assigned its inspectors to the bleeder system 24 hours a day, and required them to take methane measurements at established monitoring points every 2 hours. *Id.* at 304, 316.

In accordance with this undertaking, Tolliver had been inspecting the bleeder system everyday from January 31 through February 7. *Id.* at 304, 326-27; Tr. 829-32, 866, 868. Tolliver's methane measurements were steady except for February 4 and 7, when he measured sudden and significant increases, including near-explosive concentrations (i.e., 4.8% and 5.0%) along the tailgate side of LW49, prompting him to issue the imminent danger orders in question. 27 FMSHRC at 304, 323-27; Tr. 846-47, 855, 872-76, 879.

My colleagues have determined that these imminent danger orders cannot be upheld because Tolliver had been instructed to issue such an order if the methane level exceeded 4.5% at certain specified evaluation points. In their view, since Tolliver lacked the discretion not to issue an imminent danger order when he detected methane levels in excess of that amount, his decision to issue the orders amounts to an abuse of discretion. Slip op. at 12. My colleagues deem "unavailing" the judge's determination that Tolliver's decisions to issue the orders "were grounded more on his bona-fide concerns for, and evaluation of, the safety of miners, than on a mechanical application of instructions related by other inspectors." *Id.* (quoting 27 FMSHRC at 326). Substituting their view of the record for the conclusion drawn by the judge, the majority concludes that the instructions deprived Tolliver of the ability to make an independent judgement as to the existence of an imminent danger. *Id.* at n.14 & 14.

Although my colleagues give lip service to the substantial evidence standard of review of the judge's finding here, they fail to actually apply it. Under this test, we are not only limited to considering "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion," *Wellmore Coal Corp. v. FMSHRC*, No. 97-1280, 1997 WL 794132 at 3 (4th Cir. Dec. 30, 1997), but we also may not "substitute a competing view of the facts for the view the [judge] reasonably reached." *Donovan ex rel. Chacon v. Phelps Dodge Corp.*, 709 F.2d 86, 92 (D.C. Cir. 1983); *see also Sec'y of Labor v. Keystone Coal Mining Corp.*, 151 F.3d 1096, 1104 (D.C. Cir. 1998) (the "sensibly deferential" substantial evidence standard of review does not allow the court to reverse reasonable findings and conclusions, even if it would have weighed the evidence differently).⁴

⁴ My colleagues' reliance on *Island Creek Coal Co.*, 15 FMSHRC 339 (Mar. 1993), slip op. at 12, is misplaced. The Commission's decision to vacate the imminent danger order in that case was based "on the narrow ground that substantial evidence supports the judge's

While it is not apparent to this Commissioner that the Mine Act would necessarily invalidate an imminent danger order that was issued under the factual scenario adopted by my colleagues, there is no need to reach that question in the matter at hand. As demonstrated below, the judge's determination that Tolliver issued the orders based on his own knowledge and safety concerns is supported by persuasive record evidence.⁵ For instance, when asked why he issued an imminent danger order on February 4, Tolliver stated:

For the safety of the miners. I didn't know what was coming off of the longwall face. I knew something had happened, because I was getting pretty steady methane readings during that time, and I didn't know what happened.

At the time, I was afraid that — that the gob air might be coming on the face air on the longwall.

Tr. 851

Tolliver issued the order, not because he was robotically following instructions, but because the methane level indicated to him that the bleeder system was not working properly:

Q. . . . What was it that you were concerned could happen?

A. An explosion.

. . . .

Q. An explosion of the methane?

A. Yes.

determination that MSHA failed to meet its burden of proving that it was reasonable for the inspectors, based on the information available at the time, to conclude that the conditions in the mine constituted an imminent danger.” 15 FMSHRC at 348. The Commission declined to “reweigh the evidence in this case or to enter de novo findings based on an independent evaluation of the record.” *Id.* at 347. Here, in contrast, the majority adheres to no such constraints. Moreover, in *Island Creek* the Commission specifically pointed out that its affirmance “should not be construed as circumscribing an inspector’s authority or indeed his *obligation* to issue a section 107(a) order whenever he finds that an imminent danger exists.” *Id.* at 348 (emphasis added).

⁵ As a threshold matter, before he issued the orders, Tolliver was well aware that Cumberland was operating with a very fragile bleeder system. Tr. 860, 868.

....

Q. . . . So was that the reason that you issued the 107(a)?

....

A. Yes.

Tr. 854-55.

Tolliver's rationale for issuing the order on February 7 was similar:

Q. . . . Why did you issue the imminent danger order?

....

A. . . . I was concerned of the miners on the 49 longwall section, the safety of the miners.

Q. Do you know how many miners were on the longwall?

A. At least seven.

....

Q. Now, what was it about this high methane reading and the face, or in the longwall face, that you were concerned with?

A. An ignition or explosion due to the concentrations I was getting from the 85 crosscut.

....

Q. . . . [W]hat was the problem with the methane being where it was in relation to the people at the face?

A. I was afraid the methane was coming off the gob, going to the active longwall face. . . . [T]here wasn't enough pressure on the back side.

Tr. 876-78.

The argument that the inspector simply followed instructions and issued the orders solely on the basis of a single methane measurement was considered and rejected by the judge. 27 FMSHRC at 325-27. As he explained:

Cumberland argues that Tolliver issued the orders and citations solely because of the readings at the #85 crosscut monitoring point. While he testified to that effect, Cumberland reads too much into his responses to specific leading questions on cross-examination. Tr. 891. I find that the better interpretation of his responses was that the crosscut #85 readings were the precipitating factors for issuance of the orders and citations. His testimony, as a whole, evidences that he was concerned as much about the sudden rise in methane readings within the system, and the absence of any immediate explanation for them, as he was about the crosscut #85 readings themselves. He also considered the unfolding events with an understanding that the bleeder system was fragile. Tr. 868.

....

... Tolliver did not act solely on the basis of a single excessive methane reading, either on February 4 or 7. He considered the presence of excessive methane and unexplained sudden rises in methane in the system as a whole, and reasonably determined that the conditions he encountered on February 4 and 7 presented imminent dangers to miners. He did not abuse his discretion in issuing the orders.

27 FMSHRC at 326-27. In effect, the judge made a credibility determination, which we should not disturb except in extraordinary circumstances not found here. *Farmer v. Island Creek Coal Co.*, 14 FMSHRC 1537, 1540-41 (Sept. 1992) (quoting *Hollis v. Consolidation Coal Co.*, 6 FMSHRC 21, 25 (Jan. 1984), *aff'd mem.*, 750 F.2d 1093 (D.C. Cir. 1984)).

The testimony of MSHA's expert John Urosek also supports the judge's determination that Tolliver did not abuse his discretion in issuing the imminent danger orders. See 27 FMSHRC at 325. Urosek opined that the sudden increases in methane in conjunction with the airflow changes caused by the adjustment or movement of curtains on the headgate indicated that methane was "sitting in the internal air flow paths" of the gob, extending "all the way to the longwall face." *Id.*; Tr. 1150-52, 1155-56. He explained that the fragile bleeder system "allowed that methane to stay very close to that longwall face, so changes, inadvertent or on purpose, that occur somewhere in the system could allow that methane to come on the longwall face." Tr. 1248-49. Urosek stressed the urgent nature of the hazardous conditions, stating that, since the methane accumulations were

“already there” when Tolliver detected them, explosions could have occurred before Tolliver “even got there.” Tr. 1161-62.⁶

Based on my review of the record, I cannot conclude that there is “no evidence to support the [inspector’s] decision,” *Energy West*, 18 FMSHRC at 569. Consequently, I find that the judge correctly concluded that Tolliver’s issuance of the imminent danger withdrawal orders on February 4 and 7 did not amount to an abuse of discretion. Accordingly, I would affirm his determinations.

For the foregoing reasons, I would affirm the judge’s decision regarding the February 4 and 7 citations and orders.

Mary Lu Jordan, Commissioner

⁶ Urosek also testified about James Conrad’s discovery of a 5.1% methane level on February 14 and explained that if the methane had ignited, an explosion could have propagated towards the face in milliseconds. Tr. 1161. In fact, when asked whether there would have been enough time for Conrad to let the operator know that something was wrong so that it could make change, Urosek responded succinctly: “Mr. Conrad would not have had time to say, ‘Oh, crap.’” Tr. 1161.

Distribution

R. Henry Moore, Esq.
Jackson Kelly, PLLC
Three Gateway Center
401 Liberty Avenue, Suite 1340
Pittsburgh, PA 15222

W. Christian Schumann, Esq.
Office of the Solicitor
U.S. Department of Labor
1100 Wilson Blvd., 22nd Floor West
Arlington, VA 22209-2247

Administrative Law Judge Michael Zielinski
Federal Mine Safety & Health Review Commission
Office of Administrative Law Judges
601 New Jersey Avenue, N.W., Suite 9500
Washington, D.C. 20001-2021